

POS Response #1

The small group POS product is a three tier point-of-service product, which allows enrollees to 1) receive care within Kaiser Permanente's care delivery system under tier 1, or 2) receive care through a participating network provider/facility (PHCS) or 3) receive care from any licensed provider/facility of choice. KPIC underwrites tiers 2 and 3. Kaiser Permanente Choice Solution POS plans are available to small employers through the CalChoice exchange program.

Plan Description	POS 35 (2710/2711)			KPCS POS 25/30 (2898/2900)			KPCS POS 20 (2897/2899)		
	HMO In Network	Participating Provider	Non Participating Provider	HMO In Network	Participating Provider	Non Participating Provider	HMO In Network	Participating Provider	Non Participating Provider
Calendar Year Deductible:									
Individual	None	\$500		None	\$1,500	\$1,500	None	\$1,000	\$1,000
Family 2-member	None	\$1,000		None	\$3,000	\$3,000	None	\$2,000	\$2,000
Family 3 or more	None	\$1,500		None	\$4,500	\$4,500	None	\$3,000	\$3,000
Maximum Benefit While Insured	None	\$2,000,000		None	\$2,000,000		None	\$2,000,000	
Out of Pocket Maximum									
Individual	\$3,000	\$3,000	\$6,000	\$2,000	\$4,000	\$6,000	\$1,500	\$3,000	\$4,500
Family 2-member	\$6,000	\$6,000	\$12,000	\$4,000	\$8,000	\$12,000	\$3,000	\$6,000	\$9,000
Family 3 or more	\$6,000	\$9,000	\$18,000	\$4,000	\$12,000	\$18,000	\$3,000	\$9,000	\$14,500
Inpatient Hospital Care	\$200 per day	70%	50% Subject to a daily Benefit Maximum of \$600	\$500 copay per admission	70% Subject to a per admission deductible of \$250	50% Daily Benefit Maximum of \$1,000 per admission 1	\$250 copay per admission	80% Subject to a per admission deductible of \$250 Combined	60% Subject to a per admission deductible of \$500 Combined

								Maximum of 60 days per Calendar Year	Maximum of 60 days per Calendar Year
Office Visits	\$35 copay	\$45 copay copayment Deductible waived	50%	\$30 copay	\$40 copayment Deductible waived	50%	\$20 copay	\$30 copayment Deductible waived	60%
Preventive Care Required by PPACA	No charge	\$45 copayment Deductible waived	50% Deductible waived	No charge	\$40 copayment Deductible waived	50% Deductible waived	No charge	\$30 copayment Deductible waived	60% Deductible waived
Adult Routine Physical Exams	No charge	\$45 copayment Deductible waived	50% Deductible waived	No charge	\$40 copayment Deductible waived Limited to a maximum benefit payable of \$400 per covered exam.	50% Limited to a maximum benefit payable of \$400 per covered exam.	No charge	\$30 copayment Deductible waived Limited to a maximum benefit payable of \$400 per covered exam.	60% Limited to a maximum benefit payable of \$400 per covered exam.
Outpatient Surgery	No charge	70%	50% Benefit Maximum of \$400 per procedure	\$250 copay per procedure	70%	50%	\$100 copay per procedure	80%	60%
Xray Imaging and Lab Services	\$10 copay \$50 MRI/CT/PET	70%	50%	No charge	70%	50%	No charge	80%	60%
Emergency Care Services	\$100 copay	Covered by HMO In- Network Only, subject to a \$100 copayment, regardless of facility/hospital accessed	Covered by HMO In- Network Only, subject to a \$100 copayment, regardless of facility/hospital accessed	\$150 copay	Covered by HMO In- Network Only, subject to a \$150 copayment, regardless of facility/hospital accessed	Covered by HMO In- Network Only, subject to a \$150 copayment, regardless of facility/hospital accessed	\$100 copay	Covered by HMO In- Network Only, subject to a \$100 copayment, regardless of facility/hospital accessed	Covered by HMO In- Network Only, subject to a \$100 copayment, regardless of facility/hospital accessed

Outpatient Prescription Drugs									
Generic	\$10 copay	\$15 copayment per prescription Deductible waived	Not Covered	\$10 copay	\$20 copayment per prescription Deductible waived	Not Covered	\$10 copay	\$20 copayment per prescription Deductible waived	Not Covered
Brand/ Brand Formulary	\$35 copay	\$40 copayment per prescription Deductible waived	Not Covered	\$30 copay	\$40 copayment per prescription Deductible waived	Not Covered	\$30 v	\$40 copayment per prescription Deductible waived	Not Covered
Non Formulary	\$50 copay	\$60 copayment per prescription Deductible waived	Not Covered	\$40 copay	\$50 copayment per prescription Deductible waived	Not Covered	\$40 copay	\$50 copayment per prescription Deductible waived	Not Covered
Brand and Non-formulary Prescription Drug Deductible	None	None	N/A	None	\$250 per Calendar Year	N/A	None	None	N/A